

Surgery in South Africa is under pressure from numerous fronts. Overworked doctors, high patient loads, and poorly functioning public health care systems have all contributed to the erosion of academic surgery. Within this environment of constant challenge it is difficult to remember how privileged we are to learn and practice surgery in South Africa.

In past editions of the Needle Holder we have tried to illustrate the opportunities for success in our environment, in spite of the numerous obstacles we face. Professor Z Koto and Dr M Brand (available on the SASSiT website) have written strong pieces on the role of the surgical scientist and laparoscopy in our setting. In this edition, we present an opinion piece by Professor Jerome Loveland, Head of the Department of Paediatric Surgery, University of the Witwatersrand on his journey from medical student to head of one of the largest academic paediatric surgical centres in the Southern Hemisphere. SASSiT is committed to improving surgical training in South Africa through our numerous initiatives. We encourage you get involved, share your ideas with us and help to return the practice and teaching of surgery in South African to the extremely high standards we are known for worldwide.



by Dr Nirav Patel

Now you're a surgeon: Where to from here ?

Professor at 40, Academic Head of the largest and busiest Paediatric Surgical unit in South Africa, transplant surgeon, and chairman of the board of the "Surgeons For Little Lives" Charity, how has this 44-year-old surgeon built his career in the current milieu of academic medicine in South Africa?



Jerome Loveland guides us through his career since graduating with his MBBCh from Wits in 1997.

I worked as a reservist for Joburg's Emergency Management Services (Ambulance) Division from 1st year university, eventually resigning 14 years later in 2004. At a time when interpersonal violence, particularly penetrating trauma, was extremely prevalent in society, combined with a deluge of blunt

trauma, this pre-hospital experience gave me massive insights into the other side of life, and allowed me access to situations and people that very few other people have the opportunity to experience, probably exceeding the trauma burden of many modern day war zones. Thus after completing my internship, it was a simple decision to work for a year in the Trauma Unit at Johannesburg Hospital, and it was here that I met Ken Boffard, the first of my mentors in my surgical career. After a "gap year", the subsequent decision to apply for a registrar post in general surgery was an obvious one.

The rotation was onerous, yet extremely fun, and I truly believe that this is where my surgical foundation was laid and firmly entrenched. Core principles included a sound knowledge base and hard work, but perhaps most important was the continuity of care that we provided to our patients, the lack of which truly concerns me in today's practice hinged so strongly on limiting working hours. Rotations as a junior through ICU and trauma, and as a senior through GIT, vascular, transplant and paediatric surgery were instrumental in my progression. Focus went beyond the clinical, with emphasis and constant

encouragement in research and teaching, this from the likes of Professors Pitcher, Britz and Beale, in addition to Boffard.

At the end of general surgery, paediatric and vascular surgery held my attention, with the best of both showcased in transplantation. The dilemma was which to follow! At the time, with vascular tending towards more interventional work, compounded by the abject lack of paediatric surgeons in South Africa, I started my fellowship in Paediatric Surgery, and have never looked back. Permanently on call for 2 years, mentored by 2 great surgeons in a busy unit, with the added exposure of renal transplant and our newly formed liver transplant program, life was hectic. However the principles learned in my earlier years became indoctrinated, research was ongoing, and my daughter Laura was born. The birth of a fit, healthy, fat baby brought the stark reality of my paediatric surgical patients to bear, and certainly focused my mind on caring for these kids to the best of our ability.

However during my training a home truth was brought very strongly to reality. The most commonly referenced South African Paediatric Surgical unit was the Red Cross Children's Hospital in Cape Town.

I was dismayed! We were working in the busiest unit, with 2 (now 3...) of the most talented paediatric surgeons, yet the unit received little recognition. Clinical work was rarely converted into published data! In addition, constant fund raising events in Joburg raised millions of rands for The Children's Hospital Trust in Cape Town.

Thus it became my goal to eclipse these wrongs.....

Simultaneously our Transplant Unit expanded, providing an opportunity for a short "crash course" in liver and renal transplant in the US. This, combined with concurrent technical advances around the world, gave a colleague and I the opportunity to introduce laparoscopic donor nephrectomy as our preferred procedure for our living donors, as well as contributing to the massive growth in our unit as a whole. To date we have a thriving liver transplant program, and the operative experience gained from

this highly technical procedure has contributed enormously to my growth as a paediatric surgeon. As ever, we have focused on publishing our clinical experience from our transplant experience, ensuring that we document our success and failures, and allowing comparison to the international standard.

So I think that success is sometimes defined by stepping out of one's comfort zones, embracing opportunities that may not in fact exist in an established environment. A maxim that I firmly believe in is the following:

"It is one thing to succeed in an established environment; quite another to establish that environment and thereby breed success"

Thus, when an opportunity presented itself to move to the Department of Paediatric Surgery at Baragwanath Hospital, I grabbed it, well aware that we faced a mammoth task in turning the department around. At that point in time our service fell well short of the unit at CMJAH, let alone my aspiration of surpassing Red Cross as SA's leading paediatric surgical unit.

So if I tell you that now we categorically DO run the leading unit in the country, how did we achieve our goal?

Well with opportunity comes challenge. How often people tell you that it can't be done, this sentiment often from the very institutions that you are supposedly working with and for. Within 2 years of moving to Bara, the existing consultants had retired or left, leaving me and my close Italian friend and colleague, Valerio Gentilino, as the 2 consultants. A year later it was just me! However, already concentrating on the basic principles of patient care, translating our experience into basic clinical research, we slowly expanded the department, attracting young dynamic consultants from across the country, and growing our registrar pool, ensuring that we could offer them consultant posts once qualified. Having expanded from 2 to 10 registrars, we are proud of our 100% pass rate at the CMSA exit exam!

Whilst I have no doubt that the Department of Health, hospital management, and university ultimately support our work, at times the bureaucratic processes that drive these institutions are tedious, and not conducive to expediently supporting the patient outcomes, goals and initiatives that we strive to achieve. Whilst often demoralizing, with the potential to discourage staff and derail projects, the solution is simple, and rather than adopt a defeatist attitude and abort, the alternate is to “vok maar vort”, put the project together, and present the respective institutions with the completed solution, a fait accompli. At this point the result is gladly received and a somewhat irritating consequence is how the same institutions are now happy to reap the benefits! Whilst frustrating, remember that at the end of the day we are working for the benefit of our patients, with the sole purpose of treating them at a standard of care equivalent to that of units in the developed world, minimizing morbidity and mortality, and optimizing their hospital experience.

I think that an important component of full time state practice is the role of RWOPS, or limited private practice. Whilst controversial, and undoubtedly open to abuse, I believe that when undertaken in a well-regulated manner, RWOPS can be extremely beneficial. First and foremost it allows patients in the private sector access to the world-class academic care that patients in the state sector receive. More importantly however is the fact that patients from both groups are included in a single database, included in all research, allowing truly reflective assessment of morbidity and mortality, as well as long-term outcomes. Finally, viewing paediatric surgery as a single entity, the private practice component has invested significantly in the Wits Department of Paediatric Surgery, employing full time human resources in the state sector. The final benefit is the enormous training opportunity that the private sector holds for the training of registrars.

All too well aware of the challenges that we face, particularly with respect to the obvious financial restraints in the state sector, we embarked on creating a charity, with the express aim of optimizing

the care that our paediatric surgical patients receive in the state health care sector. This is by no means a novel concept, and worldwide, many leading children’s hospitals are significantly financed by charitable contributions. Thus, in 2015, Surgeons For Little Lives was born, and through the committed work of the board, and generous donations of time, intellect, resource and money from the community, we have built a highly successful charity, providing sustainable solutions to the care of the children treated in our hospitals.

www.surgeonsforlittlives.org

So I think that in conclusion, my short career has allowed development on many fronts, however always centred on providing optimal patient care. The numerous challenges I guess have simply been overcome with persistence, and perhaps strategizing and acting very much outside of the bureaucratic box of institutionalized thinking! Where opportunities have arisen we have grabbed them with enthusiasm, often converting pipe dreams into reality. The current challenge remains administering all of these endeavors, continuing to grow and develop them, without dropping a ball. Simultaneous to this is the constant fight to prove oneself to the masters of the house.....

I think that the danger amongst all of this is maintaining balance across the spectrum of one’s life, in particular maintaining a strong family. Thus, within the structure of our institutionalized work environment, I have always found it an absolute necessity to compromise at times, ensuring that exercise (running is my drug!) and my family are vital components, often prioritized ahead of work commitments.

Finally, none of this would have been possible without support at numerous levels, my large committed team of colleagues in the various departments and institutions that I work with, but most importantly from my wife Adele, and kids, Laura and Alec, who are always certain to support me, set me straight when I err, and provide unconditional love. ●